The Place of Immanuel/Theophostic-based[1] Emotional Healing

In the Treatment of Clinical Disorders

Dr. Smith's training material, recent research, published case studies, and anecdotal accounts all indicate that Immanuel/Theophostic-based emotional healing has been used in the treatment of many different clinical disorders.[2] However, some critics have expressed concern that these new approaches to emotional healing are being included in the treatment of serious mental health concerns without adequate research support. For example, Dr. David Entwistle states: "It is troubling that TPM is being used to treat serious and diverse disorders absent any published empirical research on TP supporting its efficacy across such applications." This comment, along with additional discussion included in Dr. Entwistle's published critique, imply that practitioners should wait for published empirical research before using a new treatment tool, and that it is irresponsible, unsafe, unprofessional, and unethical to include the Immanuel approach or Theophostic-based emotional healing in the treatment of a serious mental health concern before empirical research has been published supporting the use of these new approaches for the specific clinical disorder in question.[3]

Based on the considerations discussed below, my assessment is that this demand for published empirical research specifically addressing the application in question, *before* trying any new treatment method, is not realistic in the real world of actual medicine, mental health care, and emotional healing ministry.

1.) Treatment decisions on the basis of case studies: It is a very common practice, in all branches of medicine, in mental health care, and in emotional healing ministry, for care providers to use treatment methods and/or medication applications described in case studies, even though the treatment methods and/or medication applications have not yet been "proven" in "published empirical research." There are often many years between the case study description of a new treatment method and/or medication application, and confirmation of the new method/medication application in "published empirical research." In fact, empirical research, such as blinded, controlled studies, are often undertaken only after many practitioners have begun to use a new treatment on the basis of case study reports, and enough patients report positive results to justify embarking on more systematic research (which is tedious, time-consuming, and expensive). Millions of patients have been effectively treated with treatment methods and/or medication applications described in case studies, but not yet supported by "published empirical research."

For example, several years ago I read a case study in one of my professional journals describing a patient with treatment-resistant rapid cycling bipolar disorder. The patient described in the case study had improved dramatically with the addition of a certain kind of thyroid medication to her previous medication regimen. I had a patient whose clinical picture was very similar, and so tried the medication combination described in the case study. The thyroid medication was *not* FDA approved for rapid cycling bipolar, and had *not* been confirmed as effective for rapid cycling bipolar in any kind of empirical research study; however, I tried the proposed treatment plan on the strength of the carefully described case study. My patient experienced dramatic and lasting improvement, for which she is profoundly grateful.

Furthermore, many practitioners in the real world of actual medical and mental health care make treatment decisions on the basis of informal case studies described by respected and trusted colleagues. It is VERY common for a medical or mental health professional to get together with several of her colleagues, and ask "I have a patient with the following clinical picture....(fill in the blank). I have already tried....(fill in the blank – usually the established treatments that have already been supported by published empirical research), but they have not been effective in this case. Have any of you found something that worked in a case like this?" The others present then exchange stories about any discoveries made in their personal practices. If one of her colleagues – someone she knows, respects, and trusts – reports discovering a medication and/or method that seemed effective in a similar situation, many (most?) practitioners will then begin to test this treatment option in their own practice.

There are already several carefully described case studies of Immanuel and/or Theophostic® principles and techniques being used in the effective treatment of various serious mental health conditions (for example, the bulimia case study presented on the Case Studies page of our web site www.kclehman.com, and also the panic attack case study presented in one of our video tapes). There are probably some practitioners (both mental health professionals and lay ministers) trying Immanuel/Theophostic®-based emotional healing for these conditions based on these published case studies. And I'm sure there are also many practitioners who are trying Immanuel/Theophostic®-based emotional healing in response to informal case studies described by respected and trusted colleagues.

2.) Shared principles and techniques with research-supported psychotherapies provide indirect research support for the Immanuel approach and Theophostic®: As of April 2002, extensive medical and psychological research shows that EMDR (Eye Movement Desensitization and Reprocessing), exposure therapy, and cognitive-behavioral therapy significantly reduce the signs and symptoms of a number of mental illnesses, including Post Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), and panic disorder.[4] As discussed in the essays footnoted below,[5] my assessment is that the Immanuel approach and Theophostic®-based emotional healing include the best principles and techniques from each of these other modalities, and then add important principles and techniques not included in cognitive therapy, exposure therapy, or EMDR. If these other techniques have strong research support for efficacy, and the Immanuel approach and Theophostic®-based emotional healing include the best principles and techniques from these psychotherapies, then the research demonstrating that these other psychotherapies are effective would predict that the Immanuel approach and Theophostic®-based emotional healing will *probably* also be effective. The theoretical connections to research-supported psychotherapies provide strong *indirect* research support for the efficacy of the Immanuel approach and Theophostic®-based emotional healing. Medical researchers frequently use this logic in developing new treatments. For example, if a certain medication is effective for a particular illness, then there is a good chance that similar chemical compounds will also be effective for this same illness. When medical researchers are looking for additional treatment options, they often start with these similar chemical compounds since they are "good bets."[6]

3.) Application of Immanuel and Theophostic® principles and techniques on the basis of theoretical considerations: Medical and mental health professionals often make treatment decisions based on theoretical considerations, even though there is not yet empirical research proving that the specific treatment in question is effective for the specific application in question. For example, there is strong case study support for Immanuel and Theophostic® principles and techniques being effective for resolving the psychological effects of traumatic

events. And there is also a lot of data indicating that unresolved psychological trauma contributes to many mental illnesses, such as dysthymia, depression, eating disorders, anxiety disorders, addictions, somatization disorders, personality disorders, and the obvious posttraumatic stress disorder (PTSD).[7] If unresolved psychological trauma contributes to these mental health problems, and Immanuel and Theophostic® principles and techniques are thought to be helpful in working with psychological trauma, then it is reasonable to include the Immanuel approach and/or Theophostic®-based emotional healing in the overall treatment plan of people with these mental health concerns.

This approach is a long established and widely accepted practice in medicine and mental health care, and it has resulted in good outcomes in many individual cases, as well as leading to many important discoveries. For example, the cure for malaria was discovered when Jesuit priests at missions in the foothills of the Andes mountains observed that the Native Americans drank powdered cinchona bark in hot water to calm their trembling muscles when they were shivering from cold exposure. It occurred to the priests that cinchona might therefore also be helpful for the intense shivering that is associated with malaria, and they tested the powdered bark on several patients suffering from malarial fever. They were pleased when this treatment proved helpful in controlling the shivering, but much more excited to discover that it also cured the underlying illness![8]

Published case studies provide a large supply of additional examples, since many of the case studies published in medical journals are examples of treatment plans, *that do not yet have published empirical research support*, that have been chosen on the basis of theoretical considerations, and that appear to have resulted in good outcomes.[9]

An article about treatment for psychological trauma in a February 2005 mainstream medical journal provides still more evidence that it is common practice to make treatment decisions based on theoretical considerations in situations where there is not yet published empirical research. The author summarizes a series of interventions "recommended by expert panelists," and then simply states, without any apology or apparent embarrassment, that these recommended interventions "have not been tested empirically."[10]

I have used this approach of making treatment decisions on the basis of theoretical considerations in my own psychiatric practice, with respect to both psychotherapy tools and psychiatric medications, and have seen great benefit and minimal difficulty.

4.) Comparison to other therapies: Somewhere in the middle of my psychiatric residency training, I briefly reviewed a book that summarized the different psychotherapies available in the United States at that time. This book listed ***almost six hundred*** different psychotherapy approaches, and I'm sure a number of new psychotherapies have been developed in the 15+ years since this book was published. As far as I am aware, there is published empirical research support for only a handful of psychotherapies – cognitive behavioral therapy, exposure therapy, eye movement desensitization and reprocessing (EMDR), and biofeedback. Furthermore, these select psychotherapy modalities have empirical research demonstrating efficacy for *certain, specific* mental health problems, but they are also often used for other mental health concerns – specific applications for which there is *not yet research support*.[11] What this means is that the vast majority (~99+%?) of specific psychotherapy applications are currently *not* supported by published empirical research.

It is good to keep working towards empirical research support, but in the mean time, it does not

seem reasonable to demand that the Immanuel approach and Theophostic®-based emotional healing abide by standards that are *not* met by 99% of the psychotherapies currently available to the general public in the United States.

5.) Comparison to other emotional healing ministries: There are a large number of Christian emotional healing ministries other than the Immanuel approach and Theophostic®.[12] As with the Immanuel approach and Theophostic®, the materials published by these other ministries include many individual case descriptions indicating that these ministries are helpful for a wide variety of different mental health concerns, but there are not any published empirical research studies demonstrating that any of these other Christian emotional healing ministries are effective for the many different mental health problems to which they have been applied. It seems unreasonable to conclude that the many case reports do not qualify as valid data, and to insist that none of these Christian emotional healing ministries can be included in the treatment plan for a given mental health concern until there is published empirical research proving efficacy.

6.) Informed consent: A simple and important part of addressing lack of published empirical research support is to clearly acknowledge this in the informed consent process. In the field of mental health care, this is the accepted way to deal with the humbling reality that *most* psychotherapy tools do not have published empirical research demonstrating efficacy for many of the specific clinical problems to which they are applied (and this same practice would be appropriate for Christian emotional healing ministries). For example, the informed consent form I use for the Immanuel approach and Theophostic®-based emotional healing in my psychiatric practice includes the following text: "There is not yet any empirical research proving that the Immanuel approach or Theophostic®-based emotional healing are effective (several research projects are in process, but we do not yet have statistically significant empirical research results proving that Theophostic®-based emotional healing is effective)."[13] I explain the reasons why I think the Immanuel approach and/or Theophostic®-based emotional healing would be helpful, and also inform them that there is not yet published empirical research demonstrating efficacy. In this context, it is not inappropriate, unprofessional, irresponsible, or unethical to allow the person receiving therapy/ministry to make his own informed decision regarding whether or not to include the Immanuel approach and/or Theophostic®-based emotional healing in his treatment plan.

In conclusion, I agree with those, such as Dr. Entwistle, who believe the Christian emotional healing community should work towards empirical research to verify the efficacy of the Immanuel approach and Theophostic® for specific clinical conditions. However, pending published empirical research, I think it is appropriate to use the Immanuel approach and Theophostic®-based emotional healing in the care of various mental health concerns, including some major mental illnesses, on the basis of case study evidence and theoretical considerations. My assessment is that both case study evidence and theoretical considerations indicate that the Immanuel approach and Theophostic-based emotional healing can be helpful for any mental health concern where unresolved traumatic memories are contributing to the overall clinical picture. Furthermore, shared principles and techniques with research-supported psychotherapies already provide indirect research support for the Immanuel approach and Theophostic,® and the current lack of direct research support can be addressed in a simple and straightforward way via adequate informed consent.

****See final end note for comments regarding our place in the Theophostic community**[14]**

End notes:

1. We use the term "Theophostic®-based" to refer to therapies and/or ministries that are built around a core of Theophostic® principles and techniques, but that are not exactly identical to Theophostic® Prayer Ministry as taught by Dr. Ed Smith. Our own therapy/ministry would be a good example of "Theophostic®-based" therapy/ministry – it is built around a core of Theophostic® principles and techniques, but it sometimes also includes material that is not a part of what we understand Dr. Smith to define as Theophostic® Prayer Ministry (such as our material on dealing with curses, spiritual strongholds, generational problems, and suicide-related phenomena, and our material on journaling, spiritual disciplines, and medical psychiatry).

2. For example, Dr. Smith's advanced training material specifically discusses using Theophostic in the treatment of eating disorders, obsessive compulsive disorder, addictive disorders, phobias, post traumatic stress disorder, panic disorder, attention deficit disorder, and mood disorders (Smith, Ed. *Theophostic® Ministry: Advanced Training Level One*, (Campbellsville, KY: New Creation Publishing Inc.), October 2004 update, pages 49-121). Dr. Fernando Garzon's research indicates that Theophostic is being used in the treatment of depression, general anxiety, anger issues, phobias, panic attacks, sexual abuse, physical abuse, Dissociative Identity Disorder, sexual addiction, and eating disorders (Garzon, Fernando. "How is the Research Stacking Up?" *Journal of the International Association for Theophostic® Ministry*, 2003, "First Edition," pages 4 & 8, specific quote on page 4). I have published case studies in which Immanuel/Theophostic-based emotional healing proved to be effective treatment for bulimia, panic attacks, and narcolepsy ("Freedom From Bulimia: Case Study/Testimony," Case Studies page of www.kclehman.com, 2002; live session DVD, *Lisa: Childhood Surgery, Panic Attacks, and Abreaction*, (Evanston, IL: Karl & Charlotte Lehman) 2004; and live session DVD, *Grace: Childhood Abuse Memory*, (Evanston, IL: Karl & Charlotte Lehman) 2004), and I have personally received many e-mails describing the use of Immanuel/Theophostic-based emotional healing in the treatment of a wide variety of mental health concerns.

3. Entwistle, David N. "Shedding Light on Theophostic® Ministry 2: Ethical and Legal Issues." *Journal of Psychology and Theology*. 2004, Vol. 32, No. 1, pp 35-42, specific quote on page 39.

4. See, for example, Sherman, C. "Two Modalities Rival Prolonged Exposure for PTSD." *Clinical Psychiatry News* April 2002, p. 40; Foa EB, Keane TM, Friedman MJ eds. *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies*. (Guilford Press: New York, NY), 2000; Ballenger, J. "Current treatments of the anxiety disorders in adults" *Biol-Psychiatry*. 1999 Dec 1, Vol. 46, No. 11, pages 1579-94. See also "Theophostic & EMDR: F.A.Q.'s and Common Misunderstandings" on the Articles and FAQs page of www.kclehman.com, pages 7-8 for careful discussion of the research regarding EMDR.

5. See "Cognitive Therapy and Theophostic®-based Therapy/Ministry," "Theophostic® & EMDR: F.A.Q.'s and Common Misunderstandings," and "Exposure Therapy and Theophostic®-based Therapy/Ministry" (forthcoming), on the Articles and FAQs page of www.kclehman.com, for careful discussions of both the similarities and differences between Theophostic®-based therapy/ministry and each of these psychotherapies.

6. See Hobby, Gladys L. *Penicillin: Meeting the Challenge*. (Binghamton, NY: Vail-Ballou Press) 1985, especially "New Penicillins Introduced," Chapter 11, pages 213-231, for a well documented historical account of this pattern of investigation with respect to the penicillin family of antibiotics.

7. See "Mind *and* Brain: Separate but Integrated (expanded version)" on the "Articles and FAQs" page of www.kclehman.com, pages 29-31, for a brief summary of the *extensive* evidence indicating that unresolved psychological trauma contributes to these many mental health problems.

8. Rocco, Fiammetta. *The Miraculous Fever-Tree*. (New York, NY: HarperCollins), 2003, pages 60-63.

9. See, for example, Taylor F., Cahill L., "Propanolol for reemergent posttraumatic stress disorder following an event of retraumatization: a case study," *J Trauma Stress*. 2002; Vol 15, pages 433-437. MANY similar examples can be obtained by even a cursory review of mainstream medical and mental health journals.

10. Watson, Patricia J., Shalev, Arieh Y., "Assessment and Treatment of Adult Acute Responses to Traumatic Stress Following Mass Traumatic Events," *CNS Spectrums*, February 2005, Vol. 10, No. 2, pages 123-131, specific quotes on page 127.

11. Over the last 20 years, I have noticed that case studies and other articles in the professional literature often describe these psychotherapy modalities being used for applications that do *not* yet have research support. I have also observed this same pattern in the practices of most of my mental health professional colleagues, and in my own private practice. As described elsewhere in this essay, most mental health professionals apply logic regarding theoretical considerations, use their best clinical judgment regarding what would be helpful, and then address the lack of empirical research support by including adequate informed consent.

12. See, for example, Anderson, Neil T. *The Bondage Breaker*, (Eugene, OR: Harvest House) 1993; Anderson, Neil T. *Victory over the Darkness*, (Ventura, CA: Regal Books) 1990; Bennett, Rita. *You Can Be Emotionally Free*. (Old Tappan, NJ: Fleming H. Revell) 1982; Flynn M. & Gregg D. *Inner Healing*, (Downers Grove, IL: InterVarsity Press), 1999; Kraft, Charles. *Deep Wounds, Deep Healing*, (Ann Arbor, MI: Servant Publications), 1993; Linn Dennis & Linn Matthew. *Healing of Memories*, (New York, NY: Paulist Press), 1974; MacNutt Francis. "The Inner Healing of Our Emotional Problems," chapter 13 in *Healing* (Notre Dame, IN: Ave Maria Press) 1974; Payne Leanne. Chapters 6-10 in *Restoring The Christian Soul*, (Grand Rapids, MI: Baker Books) 1991; Sandford John & Sanford Paula. *The Transformation of the Inner Man* (Tulsa, OK: Victory House Inc.) 1982; Sanford Agnes. "The Healing of the Memories," chapter 7 in *The Healing Gifts of the Spirit*, (New York, NY: Trumpet Books) 1966; Shlemon Barbara. *Healing the Hidden Self* (Notre Dame, IN: Ave Maria Press) 1982; Wimber & Springer. "Overcoming the Effects of Past Hurts," chapter 5 in *Power Healing*, (San Francisco: Harper & Row) 1987.

13. See "Informed Consent: General Comments and Sample Form for Theophostic®-based Therapy/Ministry " on the "Ministry Aids" page of www.kclehman.com for additional discussion of informed consent, and for a sample informed consent form.

14. **Regarding our place in the Theophostic® community:** We respect Dr. Smith tremendously and value our friendship with him, however, we are not in any way officially connected with or endorsed by Dr. Smith and Theophostic® Prayer Ministry. We want to share our reflections, experiences, and discoveries regarding the Christian ministry of emotional healing, and many of the thoughts we share have arisen as we have integrated Theophostic® principles and process into our professional psychiatric and lay pastoral counseling practices. But we want to be clear that the material on our web site does not *define* Theophostic® ministry. "Theophostic®" is a trademarked name, and Dr. Ed Smith, the founder and developer of Theophostic® ministry, is the only one who has the right to define Theophostic® ministry.

We have studied many sources, including medical psychiatry and neurology, psychological research, various secular psychotherapies, and various Christian emotional healing ministries. Our emotional healing ministry includes the core Theophostic® principles and techniques, but we also include "non-Theophostic®" material. For example, our material on medical psychiatry and the biological brain, EMDR, dealing with curses, dealing with spiritual strongholds, dealing with generational problems, and our material on journaling, spiritual disciplines, community, and on dealing with suicide-related phenomena are not a part of what we understand Dr. Smith to define as Theophostic® Prayer Ministry.

The material on our website is not a substitute for the Basic and Advanced Theophostic® Ministry Training provided by Dr. Smith. For further information about Theophostic® Ministry, its developer Ed Smith, D.Min., or to order training materials, please visit www.theophostic.com.